

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003984	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2014
NAME OF PROVIDER OR SUPPLIER WORTHINGTON PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for State Residential Licensure Survey</p> <p>Survey dates: November 17 & 18, 2014</p> <p>Facility number: 003984 Provider number: 003984 AIM number: n/a</p> <p>Survey team: Diana Zgonc, RN-TC Kim Perigo, RN</p> <p>Census bed type: Residential: 29 Total: 29</p> <p>Census payor type: Other: 29 Total: 29</p> <p>Sample: 5</p> <p>Worthington House was found to be in compliance with 410 IAC 26.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 11/19/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE